

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7805

Do not use this space.

1. PLACE OF DEATH

(a) County Platte Registration District No. 698
(b) Township Marshall Primary Registration District No. 5927
(c) City _____ (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (Usual place of abode, if no street address, write county or city)
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lillian Bell</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 5 - 1850</u>		
7. AGE YEARS <u>90</u>	MONTHS <u>0</u>	DAYS <u>18</u> If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Farm</u>	
	10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Marshall Twp Platte Co. Mo</u>		
FATHER	13. NAME <u>John Scott</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>	
MOTHER	15. MAIDEN NAME <u>Not known</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>	
17. INFORMANT (ADDRESS) <u>Sam Scott Weston Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Wt Bell</u> DATE <u>2-25-40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Bill Mortuary Weston Mo</u>		
20. FILED <u>2-24-1940</u> <u>J. H. Brill</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/23-1940

22. I HEREBY CERTIFY, That I attended deceased from 2/18-1938 to 2/23-1940
I last saw him alive on 2/16-1940 Death is said to have occurred on the date stated above, at 10 m.
The principal cause of death and related causes of importance were as follows:
Myocarditis
Atherosclerosis
Arthritis, atrophic.
Other contributory causes of importance: 92A

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury none
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) R. J. Pelling M.D.
(Address) Weston, Mo.

RECEIVED
District Health Officer No. 11,
District File Number 340-269
Date Filed MAR 6 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No. 838

P. O. Address Weston Mass

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **7805-**

Registration District No. **698**

Primary Registration District No. **5927**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Platte**
(b) City or town **Marshall Rural**
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME **Alvin Bravil Scott**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years **90** Months **0** Days **18** If less than one day _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **2/24/1946** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Platte**

(c) City or town **Weston (Rural)**
(If outside city or town limits write "RURAL")

(d) Street No. **Marshall Loop**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **2** day **23**
year **1946** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature **P. J. Felling** (M. D. or other) _____

Address **Weston 290** Date signed _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

